Fax Transmission Cover Sheet

Date: ______________________

Number of Pages_______ (Including this one)

To: Peer Specialist Program
The Dale Association
Fax Number: (716) 433-1961
Phone Number: (716) 433-1937 ext. 205

From: ____
Business Number: _______________________________
Fax Number: ___________________________________

Message:

<u>Prohibition of Redisclosure of Information:</u> This message is intended only for the individual agency to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the render of this message is not the intended recipient, or the employee or agency responsible for delivering the message to the intended recipient, you are hereby notified that any disseminating, distribution or copying of this communication is prohibited. If you have received this communication in error, please notify us immediately by telephone.

Peer Specialist Program: 33 Ontario Street, Lockport, NY 14094
Phone: (716) 4B3-1937 ext. 205 Fax: (716) 433-1961

Name____ Phone Number______________________________

Eligibility Determination- Please check all below that apply.

In order to be eligible for services through The Dale Association's Peer Specialist program, applicants must meet the following criteria:

_____ Age 18 or older
_____Live in Niagara County
_____Be diagnosed with or seeking treatment for a mental illness
_____Be willing to participate in Peer Specialist program services

Current/Most Recent Psychiatric Diagnosis:
____
____

My goal(s) is (are) in the following life area(s):

______Recovery & Rehabilitation
______Physical Health & Wellness
______Financial
______Housing
______Community Presence & Participation
_______Self-Help & Empowerment
_______Educational & Employment
_______Legal
_______Spirituality
_______Other_________________

Goal #1: ____
____
____

Goal #2: ____
____
____

How will you know that you no longer need services from the Peer Specialist Program?

____
____
____
____

What will be different?

____
____
____
____

CLIENT INFORMATION

First Name	**Middle Initial**	**Last Name**

Social Security #	**Date of Birth**	**Age**	**Gender** ☐ Male ☐ Female ☐ Transgender

Current Street Address	**Town**	**Zip**

Home Phone #	**Cell Phone #**	**Work / Other Phone #**

Health Insurance: ☐ Yes ☐ No ☐ Unknown
☐ **Application Pending for**: ☐ Medicaid ☐ Medicare ☐ Managed Care ☐Other ***Specify pending date of approval***:

If Medicaid – provide # **Medicaid Active**? ☐ Yes ☐ No **If no, eligible**? ☐ Yes ☐ No ☐ Unknown

If Medicare – provide # | **Other Insurance Type:** **Policy Holder:** **Policy #**

Current benefits ☐ SSI ☐ SSD ☐ Survivor's ☐ Public Assistance ☐Unemployment ☐Earned Income ☐ None

Ethnicity (check all that apply) ☐ White/Non-Hispanic ☐ African American ☐Latino ☐ Hispanic
☐ Native American/Alaskan ☐ Asian ☐ Unknown ☐Other (*specify):*

Brief physical description (approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.)

Special Needs & Preferences (physical, medical, visual, hearing, cultural/religious, language, writing, reading, developmental disability) (*specify):*
Are services required in a language other than English? ☐ No ☐ Yes *If yes, specify language*:

Marital Status ☐Single never married ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Unknown ☐Other *(specify)*

Living Situation ☐Unknown ☐Alone ☐With Child(ren), # of persons in home: _____
☐ With other family / friends, # of persons in home: _____
☐ Homeless/Streets ☐ Emergency Shelter ☐ Other *(specify)*

Is the living environment safe? ☐ Yes ☐ No ☐ Unknown
Are there weapons in the home? ☐ Unknown ☐ No ☐ Yes ***If yes, specify type***:

TREATMENT, SERVICES AND HISTORY

Services	Past 30 days Or Ongoing (√)	Past Year (√)	Prior to 1 year ago (√)	No History (√)
Psychiatric Inpatient ***(list # of times if known):***	☐	☐	☐	☐
Hospital Psychiatric Emergency Room, NO ADMISSION ***(list # of times if known):***	☐	☐	☐	☐
Emergency Mental Health / Crisis Services	☐	☐	☐	☐
Mental Health Outpatient Treatment ***(agency / provider name & next appoint date /time)***:	☐	☐	☐	☐
Residential Program ***(specify):***	☐	☐	☐	☐
Primary Medical Care	☐	☐	☐	☐
Medical Hospitalization ***(list # of times if known)***	☐	☐	☐	☐
Alcohol / Substance Abuse Treatment – ***(agency):***	☐	☐	☐	☐
☐ Case / Care Management / ☐ Health Home - ***(specify):***	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐
☐Probation ☐Parole ☐ Treatment Court ☐ Legal involvement *(specify)*	☐	☐	☐	☐
Dept. of Social Services Protective Services - ☐Child / ☐ Adult	☐	☐	☐	☐
Other ***(specify)***:	☐	☐	☐	☐

Risk and Safety Concerns *(Check all that apply–current & history of):* ☐ suicidal ideation ☐ suicide attempts ☐ self-harm
☐ homicidal ideation ☐ violence/assault ☐ alcohol/substance abuse ☐ fire setting/arson ☐ Other *(specify)*
Individual identified as high risk by: ☐ Behavioral Health Org (BHO) ☐ Health Home ☐ Other (specify) ☐ N/A

REFERRAL SOURCE INFORMATION

Referral Source Name *(Please Print):*	**Relationship to individual**:
Referral Source Signature: **Date**:	

Agency / Program:
Complete Address and Phone Number: